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A descriptive study to assess prevalence of depression among geriatric group (age 60 years and above)

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Abstract: The purpose of this study is to assess the prevalence of depression among geriatric group (age 60 years and above) in selected urban slums. A descriptive survey design was used for this study. The tool used for data collection consisted of Geriatric Depression Scale. Findings of the study revealed that,the majority i.e. 70% of the geriatrics were having poor depression score (0-5), 29% of the geriatrics were having average depression score (6-10) and only 1% geriatrics had good depression score (11-15). There was a significant difference seen in depression score and marital status i.e. depression score was high in unmarried subjects, occupation i.e. depression score was high in unemployed subjects, economic status i.e. depression score was high in dependent subjects in this study.

Key words: prevalence, depression, geriatric.

1. Introduction:

Every human being passes through the different phases of life. Old age is said to be the final phase of life one has to reach. It is otherwise known as the second childhood. This indicates care and affection that this population need. In the concept of joint family system present in Indian tradition, elderly were regarded as the supreme power in the family, but now the nuclear family has taken the place of joint family system. This type of the family system has made the position of the elderly weak in the present society. At the same time the number of elderly persons goes on increasing. The concept of nuclear family has made the dependent elderly population more vulnerable to illness. The concept has also increased the institutionalized homes in the country.

In most gerontological literature, people above 60 years of age are considered as 'old' constituting the 'elderly' segment of the population, also called senior citizen. As per WHO guidelines people aged 60-70 are called 'elderly', between 75-80 years 'old', and 85+ 'old-old'. Demographic changes are influencing health, economic activity, and social condition of people. The life expectancy which was 42 years in 1947 has increased to 65 years today, but sadly geriatric care continues to be one of the neglected sectors.

The dramatic gains in the life expectancy and the growing number of people more than 65 years of age is challenging to the mankind. For the past two decades, a new picture of the older adults has emerged. The growing old age is a concern in all developed and developing nations. According to the 2003 census there were 77 million elderly in India representing 7.5% of the country's total population. The elderly above accounted for 21.07 million and the elderly aged above eighty numbered around 6.37 million.

Increase in the elderly population has also increased the prevalence of mental illness, in that age group. Around four million people aged 60 and above are suffering from mental illness. Depression is one of the most prevailing disabling psychiatric conditions in the elderly. Depression is projected to become the leading contributor to the global burden of the disease by the year 2020. At its worst, depression can lead to suicide, which is associated with the loss of 1 million lives per year.

Besides , older people are often the victims of mental disorders on account of their fear about death and feeling of dependency, anxiety, boredom, loneliness and helplessness. Depression is a common disorder that affects 12% of the older adult population at any point in time. Geriatric depression is the most common diagnosis with a prevalence rate of 60/100 in the general population.

1.1 Conceptual Framework:

The conceptual framework of the present study is based on Modified theory of Transition by Meleis et al . The theory usage was aimed to understand the senior citizens transition towards the developmental stage of old age and to assess the nurses' role in helping them to adapt healthy lifestyle and to be free of depression.

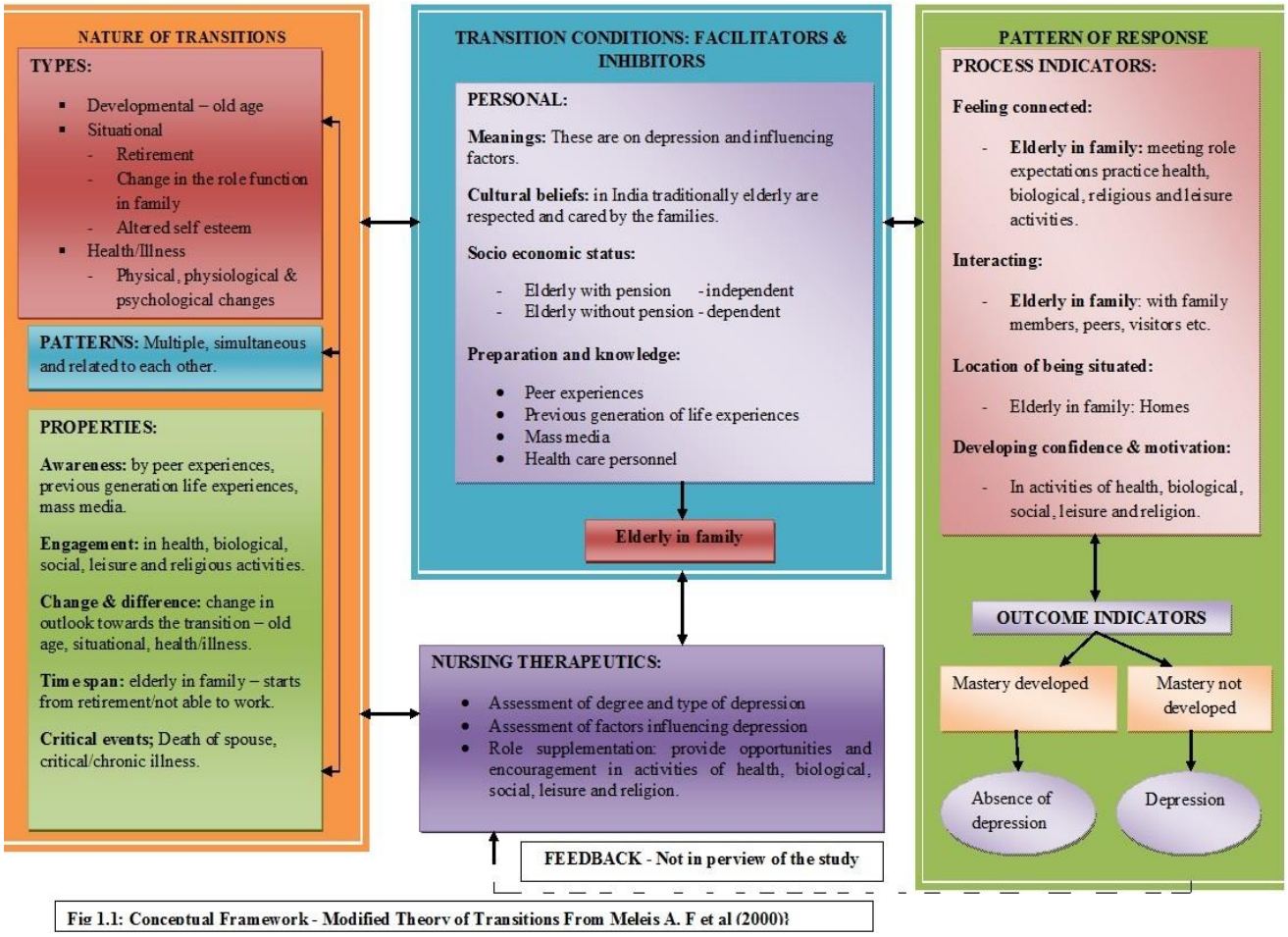

Fig 1.1: Conceptual Framework - Modified Theory of Transitions From Meleis A. F et al (2000)}

2. Review of Literature :

Ankur Barua, Nandi DN, Ajmany S, Ganguli H. (2008), conducted community-based mental health studies on prevalence of depressive disorders in the elderly. It revealed that the point prevalence of depressive disorders in the elderly population of the world varies between 10% and 20%, depending on cultural situations. A retrospective study based on analysis of various study reports was conducted, to determine the median prevalence rates of depressive disorders in the elderly population of India and various other countries in the world. All the studies that constituted the sample were conducted between 1955 and 2005. Included are only community-based, cross-sectional surveys and some prospective studies that had not excluded depression at baseline. These studies were conducted on a homogenous community of the elderly population in the world, who were selected by a simple random sampling technique. After applying the inclusion and exclusion criteria on published and indexed articles, 74 original research studies that surveyed a total of 487 275 elderly individuals, in the age group of 60 years and above, residing in various parts of the world, were included for the final analysis. The median prevalence rate and its corresponding interquartile range were calculated. The chi-square test and chi-square for linear trend were applied. A *P* value of <.05 was considered as statistically significant. The median prevalence rate of depressive disorders in the world for the elderly population was determined to be 10.3% (interquartile range [IQR], 4.7%-16.0%). The median prevalence rate of depression among the elderly Indian population was determined to be 21.9% (IQR, 11.6%–31.1%). Although there was a significant decrease in the trend of world prevalence of geriatric depression, it was significantly higher among Indians, in recent years, than the rest of the world.

Barua A, Kay DW, Henderson AS, Scott R, Wilson Jet al.(2009) conducted study to determine the prevalence of depression among the elderly population of rural areas of Udupi district, Karnataka, researcher selected 627 people in the age group of 60 years and above for the study. Simple random sampling, without replacement method, using the probability proportionate to size (PPS) technique was used. The WHO (five) well-being index (1998 version) was validated against the major International Classification of Diseases and Related Health Problems 10th Revision (ICD-10) depression inventory of mastering depression in primary care version 2.2. Proportions and their 95% confidence intervals were calculated and Kappa statistics was applied to determine the reliability of the screening instrument. *P* value<0.05 was considered statistically significant. The prevalence of depression in elderly population was determined to be 21.7% (95% CI = 18.4 -

24.9). The Indian version of WHO-five well-being index (1998 version) showed a sensitivity of 97.0%, specificity of 86.4%, positive predictive value of 66.3% and an overall accuracy of 0.89. The Kappa statistics showed significantly high reliability of *k = 0.71*.

Rajkumar, P. Thangadurai,P. Senthilkumar (2004) conducted study to assess Nature, prevalence and factors associated with depression among the elderly in a rural south Indian community. Depression in old age is an important public health problem causing considerable morbidity and disability worldwide. There is a dearth of community studies from India investigating geriatric depression and its associated risk factors. This study aimed to establish the nature, prevalence and factors associated with geriatric depression in a rural south Indian community. **Researcher** recruited 1000 participants aged over 65 years from Kaniyambadi block, Vellore, India. Researcher assessed their socio-demographic profile, psychiatric morbidity, cognitive functioning, anthropometrics and disability status using the following structured assessment tools: Geriatric Mental State, Community Screening Instrument for Dementia, Modified CERAD 10 word list learning task, History and etiology Schedule Dementia Diagnosis and Subtype, WHO Disability Assessment Scale II, and Neuropsychiatric Inventory. We adopted a case control framework to study the factors associated with geriatric depression. Prevalence of geriatric depression (ICD-10) within the previous one month was 12.7% (95% CI 10.64–14.76%). Low income (OR 1.78; 95% CI 1.08–2.91), experiencing hunger (OR 2.58; 95% CI 1.56–4.26), history of cardiac illnesses (OR 4.75; 95% CI 1.96–11.52), transient ischemic attack (OR 2.43; 95% CI 1.17–5.05), past head injury (OR 2.70; 95% CI 1.36–5.36) and diabetes (OR 2.33; 95% CI 1.15–4.72) increased the risk for geriatric depression after adjusting for other determinants.

WHO Global Burden of Disease report (2004) depression was the leading cause of burden of disease during 2000-2002, ranked as third worldwide. It is projected to reach second place of the DALYs (disability adjusted life years) ranking worldwide by the year 2020 and first place by 2030. According to a WHO report, patients over 55 years with depression have a four times higher death rate than those without depression, mostly due to heart disease or stroke. The contributions of depressive disorders to suicide are widely recognized. The Chennai Urban Rural Epidemiology study (CURES) showed the prevalence of depression among population over 20 years as 15.1%. Studies in primary care settings point to a higher prevalence of depressive disorders amongst the elderly (with chronic co-morbid diseases), ranging from 10 to 25%. A meta-analysis of 74 studies, including 487,275 elderly individuals found the worldwide prevalence rate of depressive disorders to be between 4.7 to 16%. This study indicates a comparatively higher prevalence of geriatric depression in India (21.9%).

Ajay kumar Singh, T. B. Singh, Sanjay Gupta, Jay Singh Yadav (2011) conducted study to determine the prevalence of depression and its association with medical co-morbidities among the elderly in a rural & sub-urban community setting. A cross sectional study design was used. A 15-item Geriatric Depression Scale questionnaire was used as a screening instrument. The overall prevalence of depression was 27.5%, with a higher prevalence among females (30.7%) as compared to males (23.9%). Depression was more prevalent in rural vs urban population (31.0% vs. 24.0%). Prevalence of depression was higher among elderly with medical co-morbidities (37.1%) compared to without medical co-morbidities (5.0%). Depression among the elderly was significantly associated stroke and hypothyroidism. The prevalence of depression among the elderly with medical co-morbidities in the community is high. Primary care providers need to be vigilant when treating elderly patients in their care as depression is commonly found in this group.

Swarnalatha N (1999) conducted study to assess the prevalence of depression among the elderly and to determine the epidemiological factors which are associated with depression. Design used was a cross-sectional, observational, community based study. The individuals who were aged 60 years and above were interviewed and examined. By random sampling, the villages were selected. This study was conducted through house-to-house visits in the selected villages. The prevalence of depression was 47%. The depression was high among the elderly who were aged 80 years and above (54.3%), females (56.5%), illiterates (59.0%), those who were below the poverty line (86.1%), those who were living alone (87.3%), those who were economically partially dependent (63.3%) and those depended totally for the activities of daily living (100.0%). These factors were significantly associated with depression.The prevalence of depression was found to be positively associated with increasing age, the female sex, illiteracy, a low socio-economic status, those who were living alone, those who were economically partially dependent and those who were totally dependent for the activities of daily living.

Saira Javed and Nazia Mustafa (2013) investigated the rate of prevalence of depression in various demographic variables among elderly. A study was carried out in the premises of Islamabad and Rawalpindi, Pakistan. Questionnaire based interviews were conducted among the elderly by visiting door to door. Depression was assessed by using the 15-item Geriatric Depression Scale (GDS-SF) and demographic sheet. The samples of population were 310. The age ranged from 60 to 80 years mean age was 67. The prevalence of

depression in elderly was found to be 42%. *t* test was used for analysis of data and with the help of SPSS version 14.0 results were calculated. Result revealed that there were significant differences among elderly individuals ($p<0.05$). Gender (male: n=158, 29.75%), (female: n=152, 54.61%), Marital status (married: n=201, 22.38%), (unmarried: n=109, 85%), Family system (nuclear family: n=190, 48.42%), (Joint family: n =120, 31.66%) and Occupation (employed: n=125, 19.23%), (Unemployed: n=185, 57%). In Pakistan, very few researches have been conducted on geriatrics and there is immense need to explore more and find out the cause and effect of depression, in order to take some beneficial steps towards betterment of elderly individuals. Cross sectional study should be conducted in urban and rural areas and across cultures. More over advance statistical measurements should be used.

Sreejith S. Nair, S.G. Hiremath, Ramesh, Pooja, Sreekanth S. Nair. (2013) stated that 182 participants aged over 60 from an urban area, Ashapur, Raichur were interviewed to assess their psychiatric morbidity and associated factors using geriatric depression scale. The cross sectional epidemiological study was conducted in urban slums of Ashapur, Raichur Dist. The study area has a population of 25486 with a geriatric population of 2536.A sample size of 182 was estimated using Random Sampling Technique. This study revealed that 32.4% of individuals were suffering from depression. It was concluded that prevalence of depression in geriatrics is significantly high. It is mainly associated with substance abuse, unemployment, disrupted mental status, illiteracy and poor economic status.

Bharatwaj, K.Vijaya, P. Rajaram (2011) conducted a Cross sectional Study on depression in Pondicherry. This study aimed to establish the nature, prevalence and factors associated with geriatric depression in an urban south Indian community. 100 individuals in the geriatric age group were randomly selected from among the members list of the Vilianur senior citizens society. They were administered the Geriatric depression scale and the results were compiled and analyzed by chi2 with Yates correction using the statistical software SPSS 19. Prevalence of geriatric depression was 98% with 78% mild and 20% severe depression. Majority were from the lower socio economic status. The prevalence of mild depression among males was 80.8% and it was 75.4% among females while 14.8% males had severe depression as compared to 24.5% of the females. Looking at the sleep patterns, again the proportion of severe depression was significantly higher among the ones that had a disturbed sleep (25.4%) when compared to those with a satisfactory sleep pattern (10.8%). The proportion of severe depression was significantly higher among those participants whose spouse had expired (38.8% vs. 8.1%] Geriatric depression is highly prevalent in this urban community. Higher age, disturbed sleep pattern, death of spouse etc were some of the factors that had an association with chances of depression.

Nair SS, Hiremath S (2013) conducted study on prevalence and prediction of depression in American Indian elderly. Depression research is sparse with older American Indians, and almost non-existent with Great Lakes American Indians. In our study, 309 Great Lakes American Indian elderly from urban, rural, and reservation settings were interviewed. Two-thirds of the sample were over age 65. Fifty-four percent of the sample completed less than a high school education, and 23 percent completed only a high school education. Depression prevalence and its correlates were examined. The CES-D was used to measure depressive symptomatology, and was found to have good internal consistency in our sample (alpha = .85), Overall, 18.3 percent of the sample scored above the traditional cutoff for depression (16). Both having completed fewer years of formal education and living in an urban area were significant predictors of depression.

3. Objectives

1. To assess the prevalence of depression among geriatrics
2. To co-relate the findings with selected demographic variables.

4.Materials & Method

4.1Research Approach

In this study exploratory approach was adopted, aimed at assessing depression among geriatrics (age 60 years and above)

4.2Research Design

The research design adopted for this study is non- experimental descriptive survey design,to assess depression among geriatrics (age 60 years and above)

4.3Setting of the study

The study was conducted in selected urban slums.

4.4.Sample and Sampling techniquePopulation

The target population for the study was geriatrics (60 years and above) in the urban slums. Accessible population for the present study was geriatrics (60 years and above) from selected urban slums. According to Polit and Hungler, sample is subset of a population selected to appropriate in a research study. The process selecting a portion of the population to represent the entire population the sample of the study comprised of 100 geriatrics in selected urban slums.

Non-probability Convenient sampling technique was used .

4.5. Sample Size: The study comprised of 100 geriatrics (60 years and above) in selected urban slums.

4.6. Inclusion Criteria

Geriatrics residing in selected urban slums

Geriatrics 60 years and above

4.7. Exclusion Criteria

Geriatrics diagnosed with psychiatric illness.

4.8. Tool Preparation

Data collection Instrument

The tool was prepared based on the objectives of the study. Data collection instrument is a vehicle that could obtain data patent to the study and at the same time add knowledge to the discipline.

The Instruments Used for this Study were:

1. Section I: Semi structured questionnaire to assess the demographic data.

2. Section II: Geriatric Depression Scale

Selection and Development of the tool

A tool is a written device that researcher uses to collect the data. The tool selected in the research should be as far as possible the vehicle which would be the best of up telling the data to draw conclusion pertaining to the study.

Selection of the tool

The selected tool was a structured questionnaire to assess the knowledge of mothers on behavioral problems.

Development of Tool

The following methods were used for the development of the tool:

Review of literature; viz., books, research studies, journals, newspapers, online sources, etc.

Discussion with colleagues, consultation and discussion experts from related fields.

Description of the Final Tool

In this study the team investigators used 2 tools.

Part A: Demographic data consists of 8 questions

Part B: Geriatric Depression scale items consists of 15 questions

Score interpretation

The instrument consists of 15 items related to depression among geriatrics. These items included Yes or No questions. A score of 5 or more suggested depression.

Content validity of the Tool

Validity refers to the degree to which an instrument measures what it is supposed to measure. Content validity is the extent to which a measuring instrument provides adequate coverage of the topic under study.

To establish the content validity of the tools, the prepared tool with objectives, operational definitions was submitted to 10 experts .The experts have given their suggestions regarding relevance, adequacy, and appropriateness of the items in the tool. The experts suggestions were incorporated in the tool.

Reliability of the Tool

The Reliability of the research instrument is defined as the extent to which the instrument yields the same result on repeated measures. To check the accuracy, precision, equivalence and homogeneity, the investigator's administered the questionnaire to 10 subjects who were geriatrics (age 60 years and above) in selected urban slums. Reliability of the questionnaire was calculated by split half method. The correlation of the questionnaire was tested by using Spearman Brown formula. The reliability coefficient was found to be 0.89, which indicated that the instrument is reliable.

9. Pilot Study:

A Pilot study is a small scale version or trial run of the major study. Its function is to obtain information for improving the project or assessing the feasibility. The principal focus is on the assessment of the adequacy of measurement.The pilot study was conducted in selected urban slums on 10 geriatrics (age 60 years and above), to assess feasibility of the study and to decide further plan of action .. The purpose of the study was explained to the respondents and confidentiality was assured. After obtaining their consent, the tool was administered. The study was conducted in the manner of the final data collection. The pilot study helped to visualize practical problems that could be encountered while conducting the main study. It also gave an insight into actual process of data collection and analysis. The pilot study results indicated that the study is feasible and practicable.

Method of Data Collection

The main study was conducted with 100 geriatrics (age 60 years and above) in the selected urban slums..

Formal written permission was obtained from the concerned authority prior to the data collection. Investigator's visited the urban slums and collected the data from the subjects. The first day investigator explained the purpose of the study method of data collection and time required of the geriatrics; confidentiality was assured and written consent was obtained from the participants indicating their willingness to participate in the study. The tool was administered to the subjects they were told to fill the information and hand over the completed tool to the investigators. After data collection, the investigator thanked the respondents for their participation in the study.

4.10. Data Collection

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4.11. Data Analysis& Results

The collected data has been organized, tabulated and analyzed by using descriptive & inferential statistics , i.e. percentage, mean and standard deviation where as Mann Whitney test, Wilcoxon test and ANOVA test has been used to co-relate the findings with selected demographic variables.

The data was analyzed and presented in the following sections: The data was analyzed and presented in the following sections:

Section I: Distribution of samples in relation to socio demographic data

Section II: Distribution of samples in relation to depression score

Section III: Comparison of depression score with selected demographic variables.

I

DISTRIBUTION OF SAMPLES IN RELATION TO SOCIO-DEMOGRAPHIC DATA

Table 4.1: Socio - demographic data wise distribution of cases in study group

Parameters		No of cases	Percentage (n=100)
Age (Yrs)	60 – 65	41	41
	66 – 70	40	40
	>70	19	19
Gender	Male	58	58
	Female	42	42
Marital status	Married	63	63
	Unmarried	2	2
	Divorcee	3	3
	Widow	32	32
Education	Illiterate	42	42
	Primary	43	43
	Secondary	13	13
	Graduate	2	2
Religion	Hindu	78	78
	Muslim	17	17
	Christian	5	5
Occupation	Business	11	11
	Housewife	29	29
	Labour	17	17
	Retired	18	18
	Unemployed	22	22
	Others	3	3
Economic status	Dependent	69	69
	Independent	31	31
Personal habit	Tobacco	22	22
	Misri	14	14
	Smoking	38	38
	Alcohol	23	23
	Supari	1	1
	Beatle leaf	9	9
	No	29	29

The above table shows that

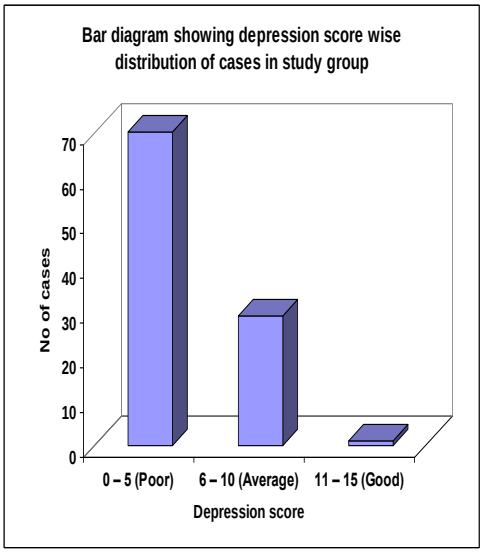
1. Out of 100 respondents, majority of 41 (41%) of them who participated in the study belonged to the age group of 60-65 yrs, 40 (40%) who participated in the study belonged to the age group of 66 - 70 yrs and remaining were in the age group of above 70 yrs.
2. Majority of samples 58 (58%) of them were males whereas remaining 42 (42%) of them were females.
3. Out of 100 respondents, 63 (63%) were married, 2(2%) were unmarried, 3(3%) were divorced and 32(32%) were widowers.
4. Out of 100 respondents, 42 (42%) were illiterate, 43 (43%) were completed their primary, 13 (13%) were completed secondary and 2(2%) were graduates.
5. 78 (78%) of them were Hindu, 17 (17%) of them were Muslim and remaining 5 (5%) were Christian.
6. Out of 100 respondents, 11(11%) were doing business, 29(29%) were housewives, 17(17%) labourers, 18(18%) were retired, 22(22%) were unemployed and 3(3%) were doing other work.
7. Out of 100 respondents, 69(69%) were dependent and 31(31%) were independent.
8. Out of 100 respondents, 22(22%) were using tobacco, 14(14%) were using misery, 38(38%) were smokers, 23(23%) were alcoholics, 1(1%) were using Supari, 9(9%) were using beatle leaves and remaining 29(29%) were not having any bad habits.

SECTION - II
DISTRIBUTION OF SAMPLES IN RELATION TO DEPRESSION SCORE

Table 4.2: Depression score wise distribution of cases in study group

Depression score	Depression score	Percentage
0 – 5 (Poor)	70	70
6 – 10 (Average)	29	29
11 – 15 (Good)	1	1
Total	100	100

Above table shows that majority 70% of the geriatrics were having poor depression score (0 - 5), 29% of the geriatrics were having averagedepression score (6-10) and only 1% geriatrics had good depression score (11-15).



Graph 4.9: Bar diagram showing depression score wise distribution of cases in study group

SECTION – III
COMPARISON OF DEPRESSION SCORE WITH SELECTED DEMOGRAPHIC VARIABLES

Table 4.3: Comparison of depression score according to age in study group

Age (Yrs)		Depression score	F Value	P Value
	n	Mean ± SD		
60 – 65	41	4.17 ±2.49	1.71	>0.05
66 – 70	40	4.25±2.45		
>70	19	5.37±2.43		

The above table shows that there is no significant difference seen in depression score according to age as the P value is >0.05.

Table 4.4: Comparison of depression score according to gender in study group

Parameter	Sex		MW test Z Value	P Value
	Male	Female		
	Mean ± SD (n=58)	Mean ± SD (n=42)		
Depression score	4.52 ±2.64	4.31 ±2.27	0.40	>0.05

The above table shows that there is no significant difference seen in depression score according to gender as the P value is >0.05.

Table 4.5: Comparison of depression score according to marital status in study group

Marital status		**Depression score**	F Value	P Value
	N	**Mean ± SD**		
Married	63	3.83 ±2.31	4.54	<0.005
Unmarried	2	8±1.41		
Divorcee	3	5.33±1.53		
Widow	32	5.31±2.52		

The above table shows that there is significant difference seen in pre test knowledge score according to marital status as the P value is <0.005.(ie. Depression score was high in unmarried).

Table 4.6: Comparison of depression score according to educational status in study group

Educational status		**Depression score**	F Value	P Value
	n	**Mean ± SD**		
Illiterate	42	4.26 ±2.38	0.79	>0.05
Primary	43	4.77±2.69		
Secondary & above	15	3.93±2.15		

The above table shows that there is no significant difference seen in depression score according to educational status as the P value is >0.05.

Table 4.7: Comparison of depression score according to religion in study group

Religion		**Depression score**	F Value	P Value
	n	**Mean ± SD**		
Hindu	78	4.24 ±2.42	5.99	<0.005
Muslim	17	4.24±1.98		
Christian	5	8±2.65		

The above table shows that there issignificant difference seen in depression score according to religion as the P value is <0.005. (ie. Depression score was high among Christians).

Table 4.8: Comparison of depression score according to occupation in study group

Occupation		**Depression score**	**F Value**	**P Value**
	n	**Mean ± SD**		
Business	11	2.73 ±2.15	2.32	<0.05
Housewife	29	4.21 ±2.24		
Labour	17	4.18±2.29		
Retired	18	5 ±2.83		
Unemployed	22	5.46±2.54		
Others	3	3.33±0.58		

The above table shows that there is significant difference seen in depression score according to occupation as the P value is <0.05. (ie. depression score was high in unemployed).

Table 4.9: Comparison of depression score according to economic status in study group

Parameter	**Economic status**		**MW test Z Value**	**P Value**
	Dependent	**Independent**		
	Mean ± SD (n=69)	**Mean ± SD (n=31)**		
Depression score	4.88 ±2.59	3.42 ±1.91	2.51	<0.05

The above table shows that there is significant difference seen in depression score according to economic status as the P value is <0.05. (ie. depression score was very high in dependent)

Table 4.10: Comparison of depression score according to personal habits in study group

Parameter	**Personal habits**		**MW test Z Value**	**P Value**
	Yes	**No**		
	Mean ± SD (n=71)	**Mean ± SD (n=29)**		
Depression score	4.66 ±2.58	3.86 ±2.17	1.48	>0.05

The above table shows that there is no significant difference seen in depression score according to personal habits as the P value is >0.05.

Conclusion:

Since depression in older adults and the elderly is often the result of a difficult life situation or challenge, any treatment plan should address that issue. If loneliness is at the root of your depression, for example, medication alone is not going to cure the problem.

The very nature of depression interferes with a person's ability to seek help, draining energy and self-esteem. For depressed seniors, raised in a time when mental illness was highly stigmatized and misunderstood, it can be even more difficult—especially if they don't believe depression is a real illness, or ashamed to ask for assistance, or fear becoming a burden to their families.

If an elderly person you care about is depressed, you can make a difference by offering emotional support. Listen to your loved one with patience and compassion. You don't need to try to "fix" someone's depression; just being there to listen is enough. Don't criticize feelings expressed, but point out realities and offer hope. You can also help by seeing that your friend or family member gets an accurate diagnosis and appropriate treatment. Help your loved one find a good doctor, accompany him or her to appointments, and offer moral support.

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